

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012377

STATE FILE NUMBER

Registration District No. 042

Primary Registration District No. 1000

Registrar's No. 365

1160 APR 20 1959

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1-57

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Nebraska b. COUNTY Lincoln	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		c. CITY OR TOWN North Platte	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2705 Folsom		d. STREET ADDRESS (If outside, give location) 4 weeks	
3. NAME OF DECEASED (Type or print) First RICHARD Middle OSBORN Last HEATON		4. DATE OF DEATH Month April Day 4 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 12, 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad Co.	
11. BIRTHPLACE (City and state or country) Fremont County, Iowa		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Richard Heaton		13b. MOTHER'S MAIDEN NAME Emma Jane Howard	
14. NAME OF HUSBAND OR WIFE unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. unknown		17. INFORMANT Mrs. Joanna Rullman, 2705 Folsom, St. Joseph, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary occlusion Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) arteriosclerotic heart disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4260		INTERVAL BETWEEN ONSET AND DEATH instant	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION St. Joseph, Mo.		20f. COUNTY North Platte STATE Nebr.	
21. I attended the deceased from March 29, 1959 to April 4, 1959 and last saw her alive on March 31, 1959 Death occurred at 2:20 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE J. E. Larson M.D. (Degree or title) 0	
22b. ADDRESS St. Joseph, Mo.		22c. DATE SIGNED 4/6/1959	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 4/6/1959	
23c. NAME OF CEMETERY OR CREMATORY North Platte, Nebr.		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR Heaton-Bowman		25. DATE RECD. BY LOCAL REG. April 14, 1959	
26. REGISTRAR'S SIGNATURE Wm. Clark Stodell			

Dr. S. E. Senior
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

APR 20 1956

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *William Spedding*

Licensed Embalmer No... *4535*

P. O. Address ... *St. Joseph, Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.